Public Health
Seattle & King County
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Health Care for the Homeless Network
A Community Program of Public Health-Seattle & County

2005 Health Care for the Homeless Network Annual Report & Data Summary

June 2006

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Acknowledgements

Health Care for the Homeless Network Planning Council. Members listed in Appendix C.

HCHN Contract Partners

Country Doctor Community Health Centers
Community Health Centers of King County
Evergreen Treatment Services
Odessa Brown Children's Clinic
Pioneer Square Clinic – Harborview Medical Center
Puget Sound Neighborhood Health Centers – 45th Street Clinic & Pike Market Medical Clinic
Seattle Indian Health Board
University of Washington Adolescent Medicine
Valley Cities Counseling & Consultation
Salvation Army William Booth Center
YWCA of Seattle-King-Snohomish County

Public Health - Seattle & King County, with particular thanks to:

Downtown Public Health Dental Clinic
Tuberculosis Control Program
King County Medical Examiner
Jail Health Services
Epidemiology, Planning, and Evaluation Section
Emergency Preparedness
Public Health Clinics

King County Department of Community & Human Services

City of Seattle Human Services Department & City of Seattle Office of Housing

National Health Care for the Homeless Council

Seattle-King County Coalition for the Homeless

HCHN Funders and In-Kind Donations 2005:

U.S. Department of Health & Human Services, HRSA, Bureau of Primary Health Care
U.S. Department of Housing & Urban Development
City of Seattle
King County
Phoebe W. Haas Charitable Trust
Small Changes (for calendars to give to patients)
Danny Huang & Diana Sharon
Anonymous

Questions about this report may be directed to Janna Wilson, HCHN Program Manager, (206) 296-4655, janna.wilson@metrokc.gov. *For assistance with this report, special thanks goes to HCHN staff Karen Eckert, Betty Helsten, and Susan Kline, ARNP. We gratefully acknowledge Tom Phillips, One on One database consulting, for his support of the HCHN database.*

Contents

A. Executive Summary

Public Health - Seattle & King County's Health Care for the Homeless Network (HCHN) is pleased to share these highlights of our 2005 work. HCHN and its community-based advisory Planning Council organize and assess a system of health care access, screening, & referral for homeless adults, families, and children in King County.

Partnerships with community-based agencies constitute the core of the Network. In 2005, HCHN contracted over $3 million to primary care clinics, mental health/substance abuse agencies, and other organizations to sustain a network of staff teams throughout King County who help homeless people access care. These partner agencies bring added support to the homeless-focused services, and contribute to the Network in a myriad of valuable ways. See page 2 for a list of partner agencies.

HCHN Database. Each time a member of the HCH Network sees a client, an HCH "encounter form" is completed and submitted to Public Health's HCHN program. A special client code is used across the network that allows us to unduplicate client data. The data in this report reflect encounter forms completed by about 48 full-time equivalent staff. About half are medical staff, predominately nurses with a few nurse practitioners, physician assistants, and doctors. About half are other types of staff, including mental health/substance abuse counselors, case managers, outreach/engagement workers, and Medicaid enrollment specialists.

2005 Observations:

- The number of HCH clients with hypertension and diabetes continued to rise in 2005 over previous years.
- Fewer HCH clients were successfully linked to community mental health services in 2005 compared to 2004, despite the fact that this is one the highest areas of need and most common health problems of HCH clients.
- More HCH clients were successfully linked to substance abuse treatment services in 2005 compared to 2004.
- Twenty-three (23) homeless people had active TB in 2005. In 2004, there were also 23 cases.
- Care for homeless people was expanded by the opening of the Third Avenue Center at YWCA Opportunity Place, by securing a federal dental care expansion grant, and by shifting existing staff to new locations.
- Several HCHN programs increased partnerships with supportive housing programs in 2005, including the Medical Respite program and enhanced Tuberculosis services.

B. 2005 Accomplishments

Access to Care for Homeless People

- 8,148 unduplicated homeless patients received 42,677 health care visits (outreach sites & homeless clinic sites).
- 14,382 public health department homeless & formerly homeless patients received 50,065 visits.
- Opened the "Third Avenue Center," on April 8, 2005 – a satellite clinic located at YWCA Opportunity Place. Partnership with Harborview Medical Center, HCHN, and the YWCA. Served 765 unduplicated patients by December 31, 2005.
- Applied for and was awarded a $150,000 dental care expansion grant; began services on August 2005 at Downtown Public Health Dental Clinic.
- Through our community partners, added services at Compass Center (Pioneer Square Clinic), DESC 1811 Eastlake (Pioneer Square Clinic), and Avondale Park (Community Health Centers of King County).
- The Health Care Access program, funded by HCHN and the YWCA, served 1,200 adults and nearly 900 children, helping them access and retain Medicaid coverage. Advocates saw clients in 20 shelter and transitional housing sites.

Case Management Programs Strengthen Ties to Supportive Housing

- REACH case management program (Evergreen Treatment Services & Pike Market Medical Clinic) helped 26 chronically homeless people move into stable housing, and supported 100 others to help them sustain their current permanent housing.
- In 2005, the enhanced Tuberculsosis program's "discharge planning" function helped 18 homeless people with TB get or sustain stable housing, rather than return to the streets.
- Pathways Home case management program moved 28 families into permanent housing, and 6 into transitional.
- Collaborated with the Compass Center to arrange access to 2 set-aside transitional housing placements per month for Medical Respite program discharges.

Communicable Disease Prevention & Health Education

- Updated *Recommended Health & Safety Best Practice Guidelines for Homeless Service Agencies* and posted on HCH website: **www.metrokc.gov/health/hchn**
- Issued newsletters and brochures on topics of interest to homeless service programs, with information on topics such as West Nile Virus, MRSA, ticks, spider bites, cold & flu season, and more.

- Flu shots: administered over 1,000 flu shots to homeless people in over 40 community sites in fall/winter 2005.
- HCH TB liaison provided 860 technical assistance contacts/trainings to homeless agencies in Seattle to help them take steps to prevent the spread of TB.
- HCH Public Health Nurse taught a weekly health issues class at the Community Center for Alternative Programs (a community corrections program).
- In August 2005, held 2 workshops on "Effective Supervision for Homeless Service Providers." Ken Kraybill & Jeff Olivet of the National Health Care for the Homeless Council trained 136 supervisors from numerous community-based agencies.
- Trained 75 homeless agency staff at two Communicable Disease Training workshops.

Quality Improvement

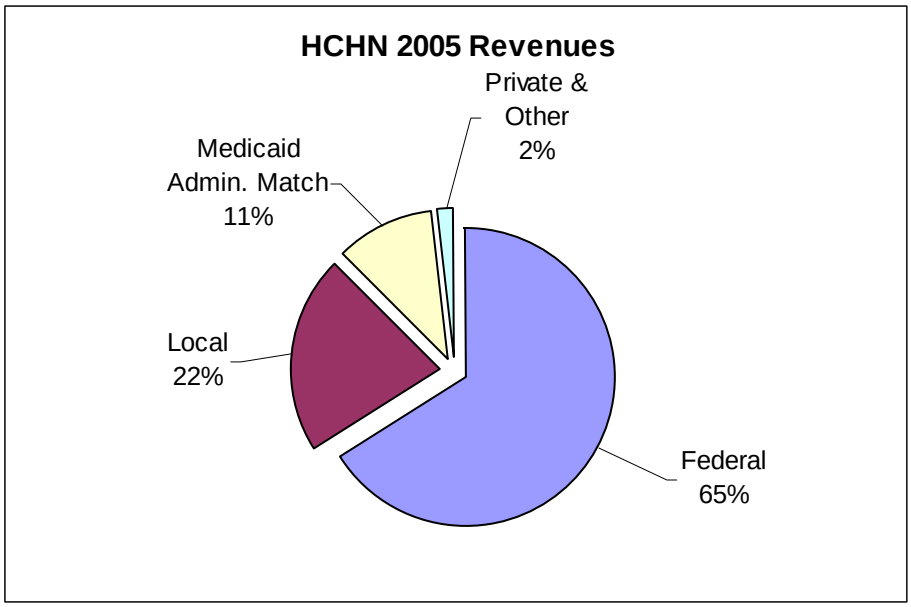
- Supported an active Quality Management committee for the HCH network, which met 4 times in 2005.
- Issued annual report on 2004 homeless deaths: 82 people died while homeless in King County.
- Carried out a process for conducting peer chart reviews of HCH care providers, including case managers.
- Initiated a quality improvement project on self-management support. Trained HCH providers on working with clients with chronic health conditions to set self-management goals. Began data collection.

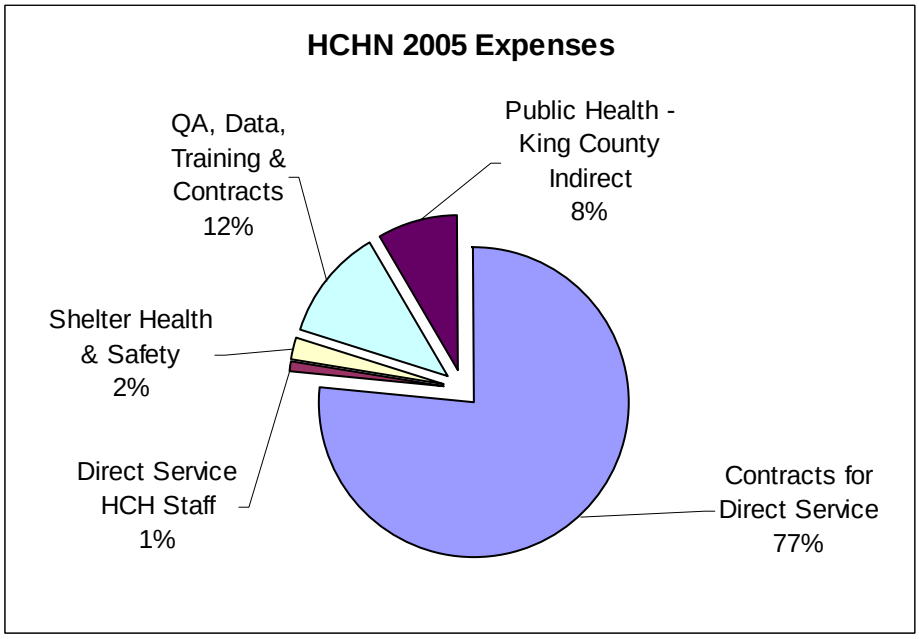
Governance & Financial

- Celebrated the Seattle-King County Health Care for the Homeless Network's 20th anniversary in March 2005. Published Op-Ed piece, and received recognition from King County Executive.
- Implemented new documentation and billing procedures to access Medicaid Administrative Match funds for HCHN's work related to informing homeless people about Medicaid, helping them link to Medicaid services, and improving the availability and quality of Medicaid services. Trained HCH staff and staff of eligible HCH contractors on the new time study process and definitions.
- Participated actively in planning and implementation activities for the Ten Year Plan to End Homelessness in King County.

C. Program Resources 2005

The HCHN program budget for 2005 was $4.3 million. Most revenue is federal – a combination of Health & Human Services (HHS) and Housing & Urban Development (HUD). The HUD funds are designated for two specific projects – the Pathways Home case management for families, and the Medical Respite program. HHS funds are allocated according to the annual application and plan submitted to HHS-Bureau of Primary Health Care.





D. HCHN Major Service Sites 2005 – Contracted Services

Through contract partnerships with health, mental health, substance abuse, and other organizations, HCHN supports geographic-based teams of nurses, counselors, and Medicaid eligibility specialists that provide assistance in selected homeless sites throughout King County. Due to limited resources, services vary by site and are not available in all homeless programs. In addition, several special programs receive support through HCHN, and are detailed further in Section F.

Sites with regular health services supported—in whole or in part, depending on the site—by Health Care for the Homeless Network:

Single Adults

Chief Seattle Club
Compass Center & Compass Cascade
Downtown Emergency Service Center
Downtown YWCA
Second Avenue Clinic (at Needle Exchange)
Third Avenue Center (at YWCA Opportunity Place) / Angeline's
DESC 1811 Eastlake *[began December 2005]*
Dutch Shisler Sobering Support Center
St. Martin de Porres Shelter
Salvation Army William Booth Center
Katherine's House

Unattached Youth

45th Street Clinic (Puget Sound Neighborhood Health Centers)
County Doctor Youth Clinic (via UW Adolescent Medicine clinic)
Eastside Youth Clinic (Community Health Centers of King County) *[closed summer 2005]*
YouthCare Orion Center

Families

Broadview Shelter – FPA
Catherine Booth House – Salvation Army
Providence Hospitality House
Domestic Abuse Women's Network
Eastside Domestic Violence Program
First Place School
Hopelink sites
Jubilee House
South King County Multi-Service Center sites
YWCA family sites countywide
New Beginnings
Our Place Day Care
Avondale Park
Rose of Lima
Sacred Heart
Seattle Emergency Housing Services (YWCA)
Union Gospel Mission Family Shelter
Morningsong Family Support Center
Family & Adult Service Center

Certain visits also take place in the client's home (once housed), streets, encampments, and other sites.

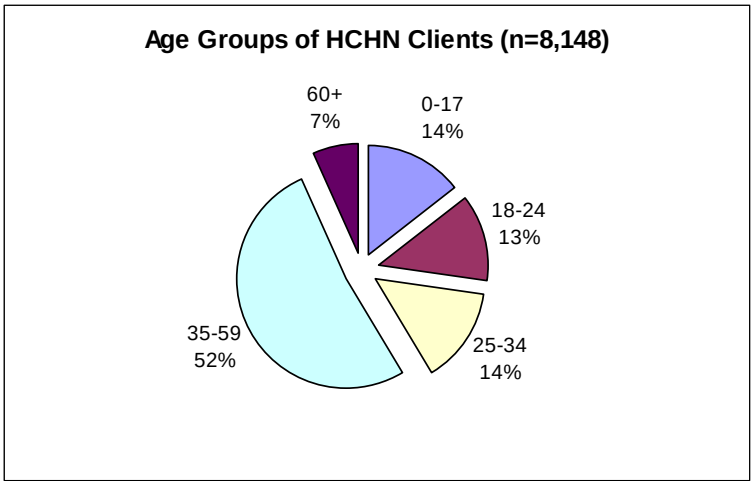
E. Summary Data – HCHN Contracted Services

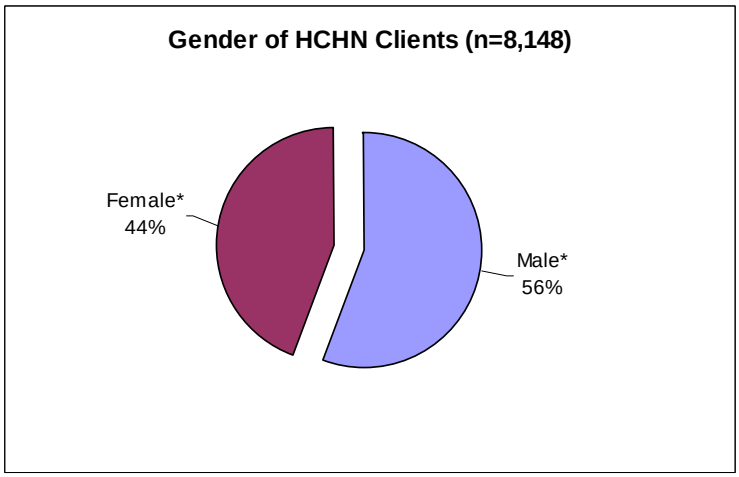
This section provides information on the 8,148 unduplicated homeless people seen through HCHN contracted services in 2005. Most services took place in homeless agency sites and homeless-focused clinic sites. Service levels are fairly consistent with previous years; variations occur due to changes in budget, service model, and sites served in any given year.

	2001	2002	2003	2004	2005
Clients	7,208	7,935	8,037	8,125	8,148
Visits	39,785	43,058	43,621	41,533	42,677

1. HCHN Client Demographics

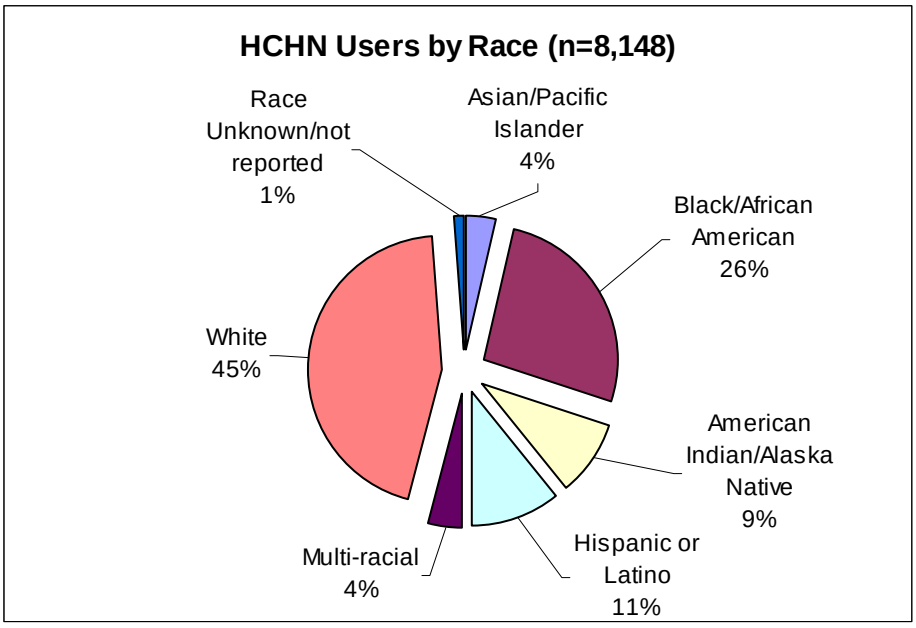
Age, gender, race, and household information are shown below. Please keep in mind this is reflective of the types homeless sites at which services are provided.





* Includes 9 female and 1 male transgendered individuals.

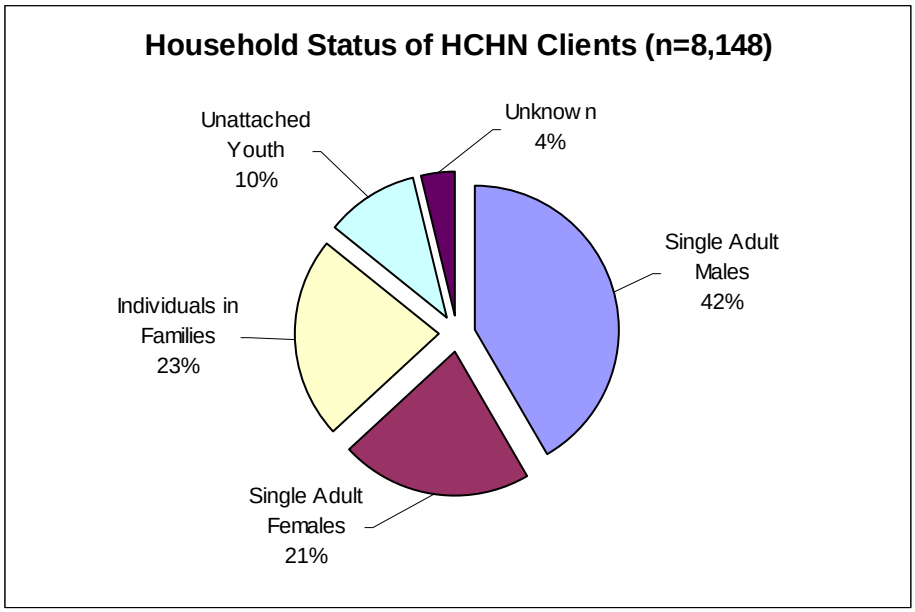
Similar to the overall homeless population of King County, over half of all HCHN clients are people of color:



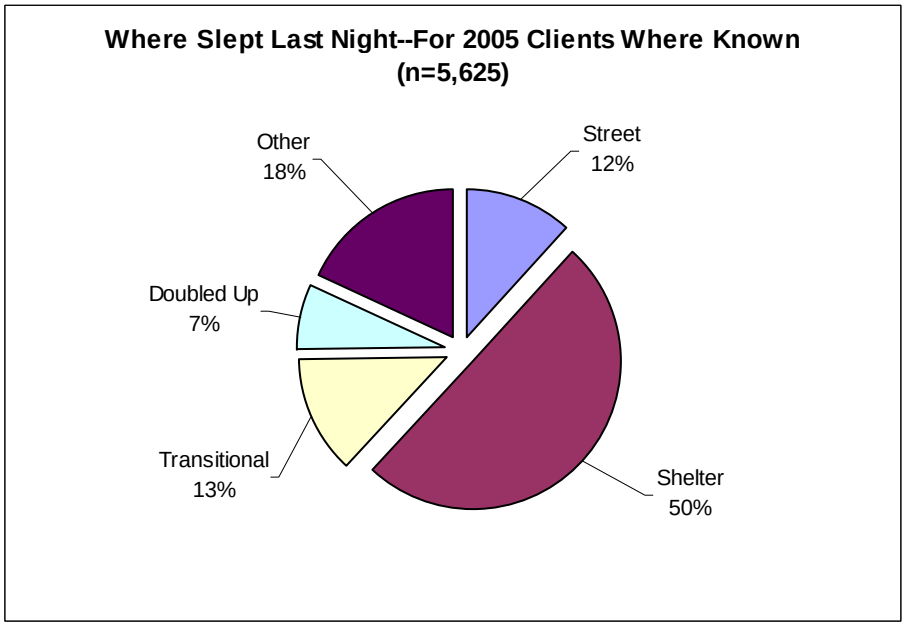
We also examined race of clients by program area:

	All HCH	Veterans	Medical Respite	Pathways Home (families)	REACH (chronic substance abuse)	Third Avenue Center
American Indian/Alaska Native	9%	12%	4%	3%	44%	5%
Asian/Pacific Islander	4%	2%	1%	2%	0%	2%
Black/African American	26%	28%	29%	31%	12%	28%
Hispanic or Latino	11%	5%	9%	14%	5%	5%
Multi-Racial/Other	4%	4%	5%	12%	4%	2%
White	45%	50%	52%	38%	36%	50%
Unknown/not reported	1%	0%	0%	0%	0%	1%

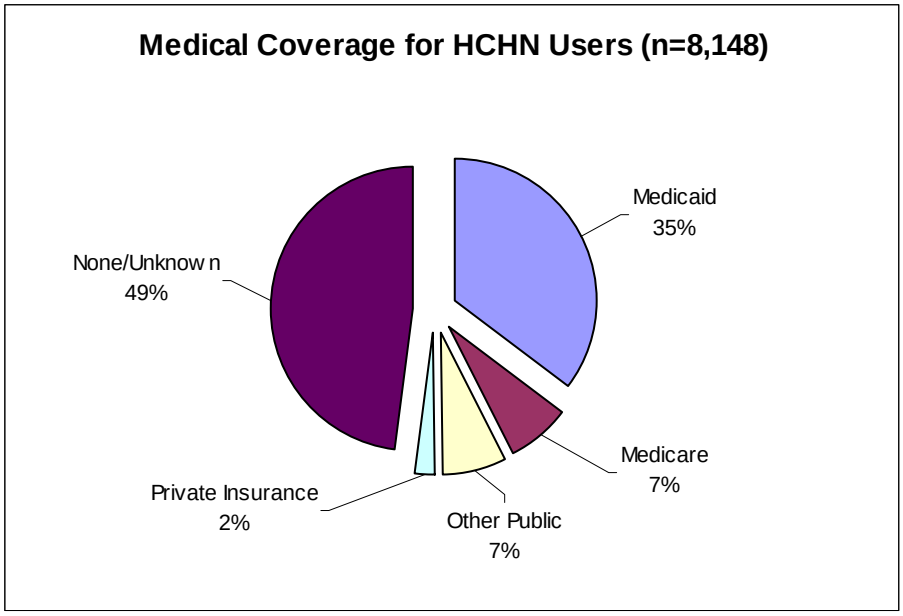
Of HCHN 2005 clients, the largest group was single adults (63%).



For 5,625 HCHN clients seen in 2005, we had information on where the individual slept the previous night. Most clients stayed in shelter, reflective of our shelter-based service model. "Other" includes locations such as hospitals, jails, the Medical Respite program, motels, and other unstable housing situations. It also includes those who were recently housed but still receiving HCHN services.



HCHN clients tend to either be uninsured or covered through Medicaid, the federal health program for low-income people. Medicaid is available mainly to families with children and people with disabilities. "Other Public" are state-only programs such as General Assistance and the Basic Health Plan.



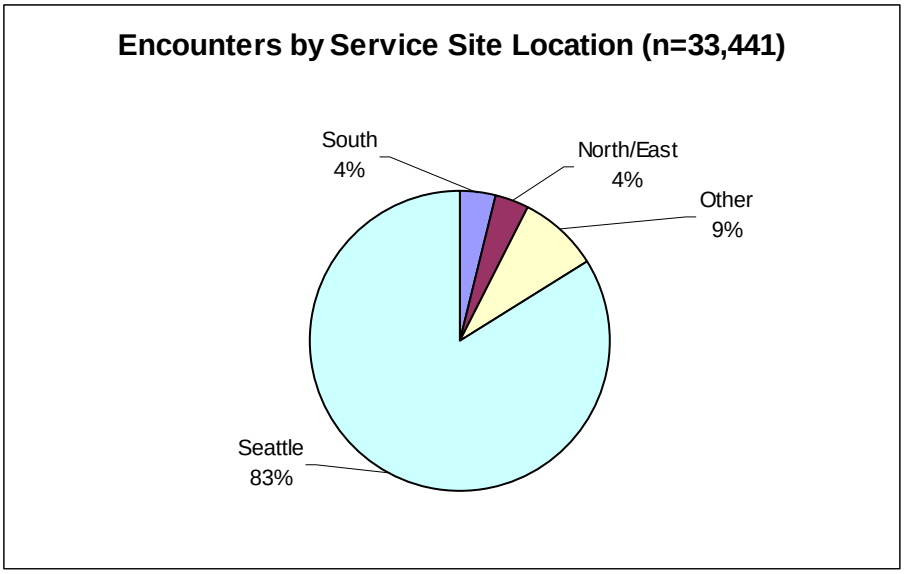
Percent of HCH Clients on Medicaid

2001	2002	2003	2004	2005
37%	39%	37%	41%	35%

2. Geographic Location of Services

The following shows the subregion of King County where the service encounters in homeless agency sites took place. This display excludes clinic-based encounters. "Other" are site code locations (such as client's home, street, and others) that do not have a geographic subregion associated with the code.

The high percentage of encounters in Seattle reflects various dynamics including: (1) the majority of homeless persons and shelters are located in Seattle; (2) the presence of large HCHN programs such as Medical Respite and REACH in Seattle; (3) nurses sited at large single adult shelters typically are able to see more individuals on a given day than a nurse working in suburban areas, where travel and other program differences are factors; and (4) City of Seattle investments in HCHN have allowed for more services for Seattle's homeless population. Need and demand for expanded HCHN services in south and east King County are high.



3. Veteran Status

In 2005, HCHN provided services to 365 unduplicated homeless veterans. HCHN staff attempt to link eligible veterans to services available to them through the VA and related programs.

Unduplicated Veterans Served by HCHN	**365**	
Vietnam Era (subset)	85	
% of total veterans served	23%	
Female	27	7%
Male	338	93%
Total	**365**	**100%**
Individual	342	94%
Family	16	4%
Unknown	7	2%
Total	**365**	**100%**
American Indian/Alaska Native	42	12%
Asian/Pacific Islander	6	2%
Black/African American	103	28%
Hispanic (all races)	18	5%
Multi-Racial/Other	13	4%
Caucasian	183	50%
Total	**365**	**100%**

At what HCHN service sites were homeless veterans most commonly seen?

The highest number of HCH visits provided to homeless veterans were at the sites listed below—not surprisingly, sites serving homeless single men topped the list. The visits in homeless sites were primarily nursing or mental health/substance abuse visits, plus some nurse practitioner/physician assistant visits.

Site	# of Visits
Men's Medical Respite Program (at William Booth Center)	892
REACH Case Management Team (at Sobering Center)	540
Pioneer Square Clinic	356
Downtown Emergency Services Center (DESC)	355
St. Martin de Porres Shelter	302
Occassional Sites	134
Client's Home	130
Seattle Indian Health Board	74

Third Avenue Center (at Opportunity Place)	73
Street, Alleys, Parks etc.	71
Chief Seattle Club	46
Angeline's Day Center	39
William Booth Center	38
The Compass Center	35
Wintonia	34
Seattle Emergency Housing Services (SEHS)	34
South King County YWCA	33

For what health problems were homeless veterans most commonly seen?

Body System	# of Visits
Substance Abuse Related	1298
Mental Health (see below)	715
Sign/Symptom	690
Skin conditions	585
Cardiovascular	428
Respiratory	279
Endocrine	197
Musculoskeletal	167
Gastrointestinal	166
Need for post-surgical care	92
Cancer	76

Mental Health breakout	***# Visits***
Depression	372
Anxiety	155
Psychoses	70
All other mental health	*214*

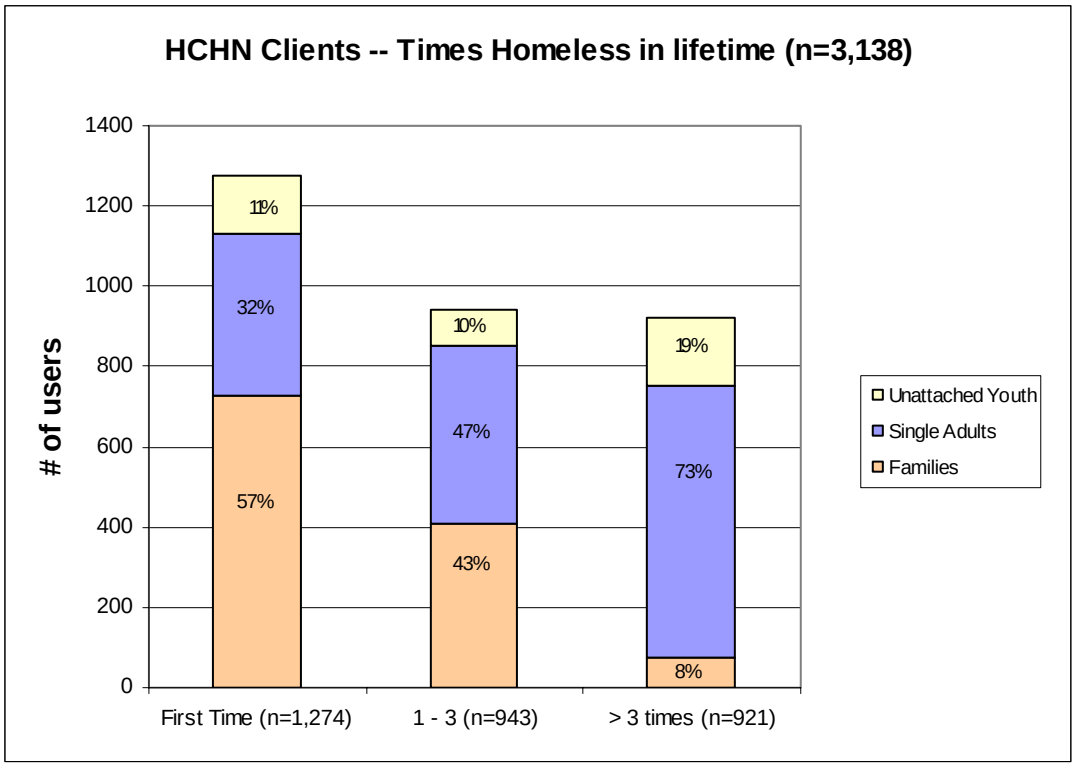
Most common Signs/Symptoms	***Instances***
Upper Respiratory	101
Skin Wound	94
Pain	69
Diarrhea	68
Cough	49
Fatigue	42
Sleep Disturbance	41
Physical Trauma	40

4. History and Length of Homelessness

History of homelessness is collected by HCHN providers where feasible.

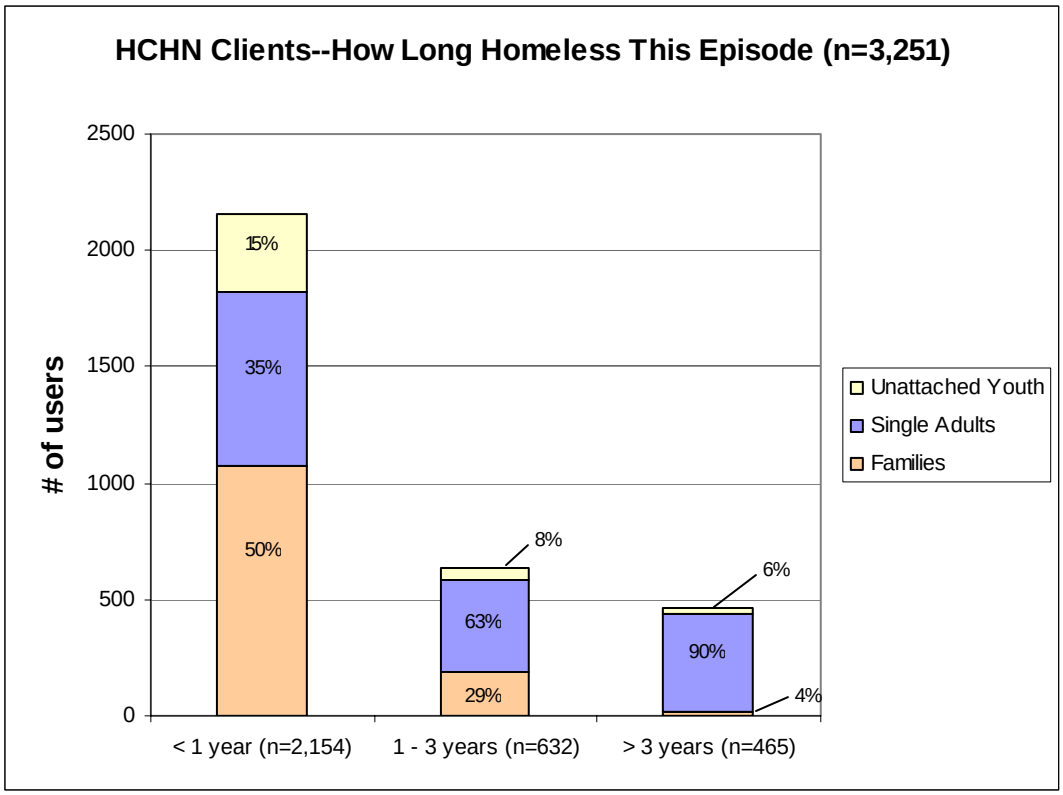
Episodes of homelessness. For 41% of HCHN clients for whom the information was known, this was their first episode of homelessness. Among that group, the majority were individuals in families. Of 921 individuals who had been homeless more than 3 times, the majority were single adults.

	2004	**2005**
N=	***2,770***	***3,138***
First time homeless	47%	41%
1-3 times homeless	29%	30%
More than 3 times	24%	29%
Total	**100%**	**100%**

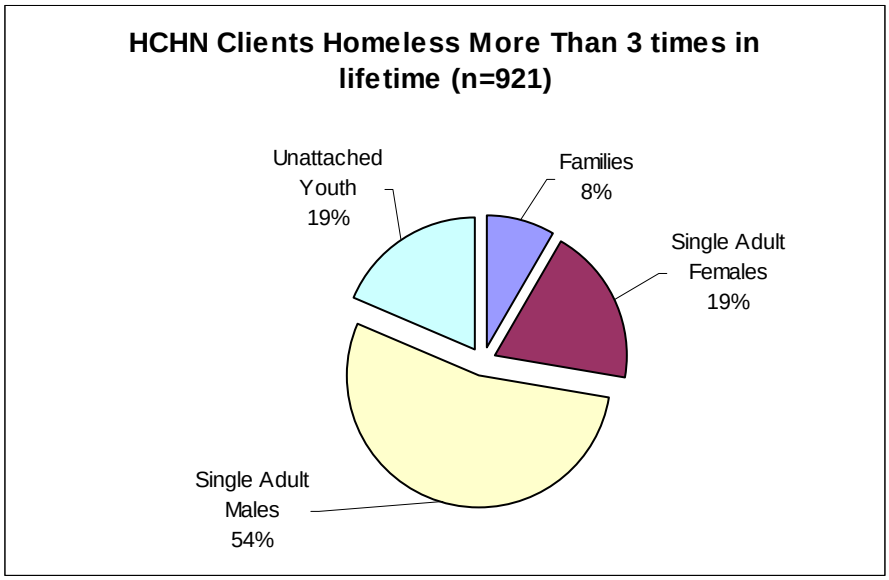


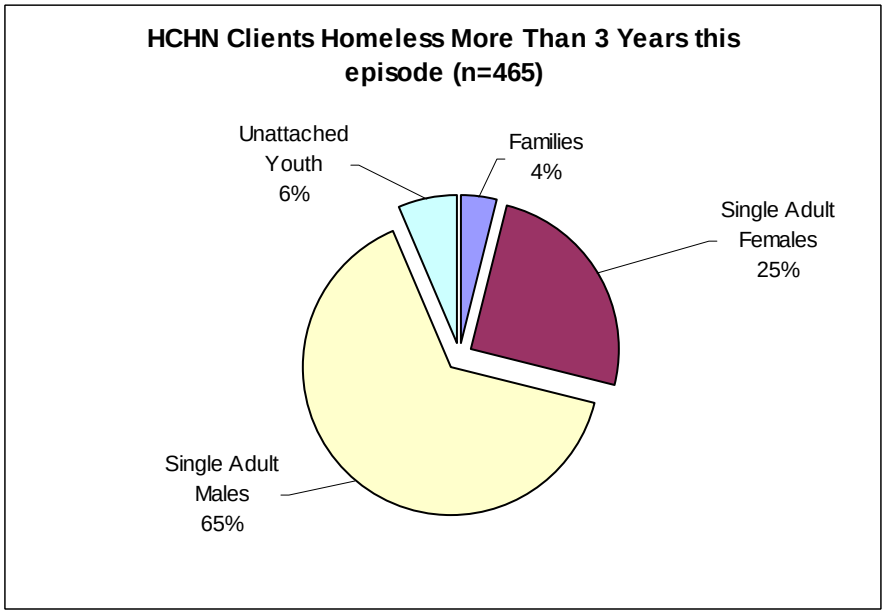
Length of current episode of homelessness. Of the HCHN clients for whom information on length of time homeless was known, 66% of them had been homeless less than one year. Of those who had been homeless more than 3 years, the majority were single adults.

	2004	**2005**	
N=	*1,039*	*3,251*	*Data was collected on more clients in 2005*
Less than a year:	58%	66%	
1-3 years:	6%	19%	
More than 3 years:	36%	14%	
Total	100%	100%	



Household status of those with longest histories of homelessness. Consistent with national data on homeless people, HCHN clients who were single adults had longer and more frequent episodes of homelessness than families or youth. However, all three subpopulations did have clients with long histories of homelessness. (It is also possible that we had easier access to the data for single adults than for other groups due to the Respite program's history and experience in collecting the data.)





5. Health Problems and Social Issues

The most common health problems of HCHN clients remain similar to those seen in past years, and reflect the harshness of life on the streets and in shelters, as well as underlying causes of homelessness. Skin conditions, upper respiratory infections, mental health and substance abuse problems, and cardiovascular problems are among the problems most frequently seen. Appendix B includes information on the specific health problems by subpopulation. The table below lists the five most common health problems seen by medical care personnel (nurses, nurse practitioners, doctors, and physician assistants).

Most Common Health Problems 2005 – Seen by Medical Staff (excludes signs & symptoms and social issues)

Rank	Single Women	Single Men	Family Adults	Family Children	Unattached Youth
1	Skin conditions	Skin conditions	Mental health	Health maintenance	Screening/No Problem
2	Respiratory	Musculoskeletal	Musculoskeletal	Respiratory	Health maintenance
3	Musculoskeletal	Respiratory	Screening/No Problem	Screening/No Problem	Skin conditions
4	Mental health	Cardiovascular	Substance abuse related	Skin conditions	Respiratory
5	Screening/No Problem	Substance abuse related	Respiratory	Mental health	Musculoskeletal

Skin conditions run as a common thread among the population groups. For children, eczema, diaper rash, fungal conditions, and impetigo[1] are common problems. Among adults, cellulitis (a skin infection which left untreated can spread), abscesses (often related to intravenous drug use), and lice and scabies are common problems.

Respiratory conditions in the homeless population frequently include the common cold, acute and chronic bronchitis, sinusitis, and asthma. Musculoskeletal conditions include a broad range of problems such as arthritis, back pain, and foot and shoulder problems among many others.

For children and youth, health maintenance refers to visits where services such as well child checks, health education, and immunizations take place. Screening/no problem means that a nurse did a general health screening but identified no problems or services needed.

[1] A contagious bacterial infection of the superficial layer of the skin. The bacteria usually infect skin that has been damaged by scratching an insect bite or picking a scab.

Number and % of HCHN clients with specific health issues

		% of total users with this condition
Signs & symptoms (see breakdown below)	3,681	45%
Mental Health issues (see breakdown below)	1,730	21%
Skin conditions	1,691	21%
Substance Abuse Related	1,506	18%
Respiratory conditions	1,399	17%
Musculoskeletal	1,269	16%

Most common signs & symptoms include:

Sign or symptom	***# of Users***
Emotional/adjustment/situational issue	868
Upper respiratory symptoms	637
Skin wound	573
Cough	395
Fatigue	389
Sleep disturbance	315
Headache	291
Abdominal Discomfort	246
All other signs & symptoms	817

Mental health issues include:

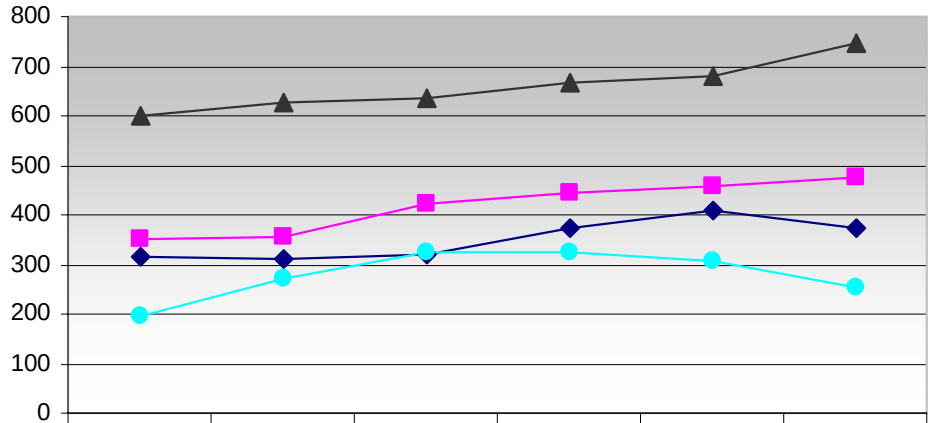
Issue	***# of Users***
Depression	1,166
Anxiety	517
Psychoses	194
All other mental health	635

Chronic Health Problems. In 2005, about 15% of the HCH patients (1,195) were reported as having at least one chronic health condition. The most common chronic conditions reported were:

(1) depression and other mental health problems
(2) substance abuse related conditions
(3) cardiovascular conditions; and
(4) respiratory conditions

These are the same top chronic health conditions we saw in 2004.

Number of HCH Users With Selected Problems, 2000-2005
Note: # of users each year remained constant at about 8,000 people



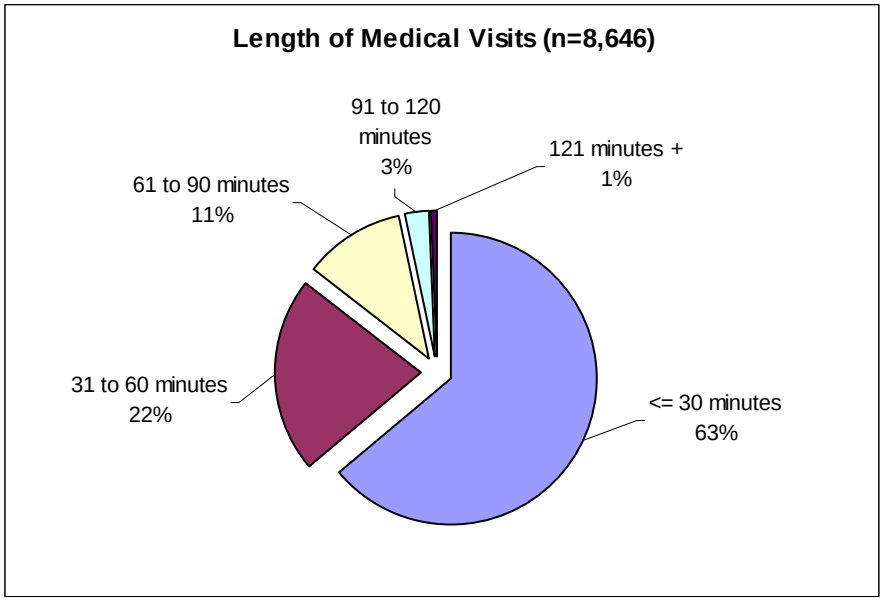
	2000	2001	2002	2003	2004	2005
Asthma	316	309	321	373	410	374
Diabetes	351	355	424	446	459	477
Hypertension	599	627	634	667	681	746
Nutrition Problem	196	273	324	326	307	254

Social Issues/Needs. During each visit with an HCHN Provider, the client is assessed for other pressing, unaddressed social issues related to their homelessness.

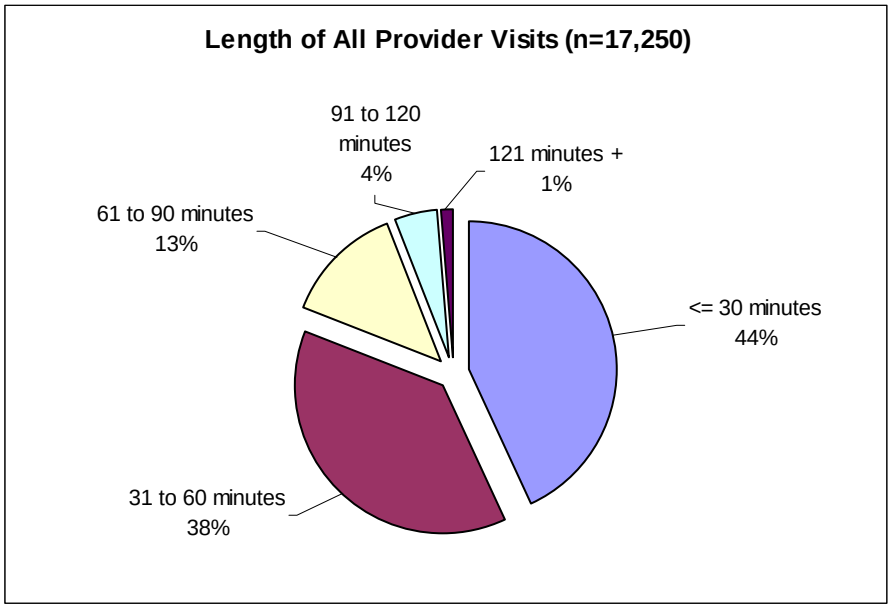
Social Need	# of Visits Where This Issue was Identified
Housing	2,073
Entitlements/Benefits	983
Primary Health Care Provider Needed	730
Domestic Violence	561
Parenting Issues	468
Abuse--emotional, physical, sexual	373
Employment	348
Transportation	329
Child Care/School	285
Financial Management/Budgeting	264
Food Insecurity/hunger	245
Legal	210

Length of Visits

For the first time in 2005, we examined the length of the HCH visits provided by medical staff – including nurses, nurse practitioners, physician assistants, doctors, and other medical care staff.



The following chart shows the length of visit for *all* types of HCH staff, including case managers and counselors whose visit length is typically longer than that of a medical provider.



6. Referrals Made and Completed

When an HCHN provider sees a homeless individual and makes a referral for that client to another service, this is indicated on the encounter form. If the HCHN provider later knows whether the client followed through or not, the information is updated to indicate whether the client received care, did not receive care, was lost to follow up, or unknown. Because homeless people move frequently, many clients are only seen once while in a shelter stay and the HCHN provider has no way of knowing whether follow-up on a given referral took place.

We know that, at a minimum, about half of all referrals made by HCHN providers resulted in care actually being received by the client. The total number of referrals made also rose from 2004, perhaps reflecting better tracking of referrals made & completed by HCH staff.

	2004	**2005**
Total Referrals Recorded by HCH Staff	9,982	14,528
Know to Have Received Care	5,474	7,052
% Received Care	55%	49%

Notable differences from 2004 to 2005

- **Substance abuse treatment**. The number of **substance abuse treatment** referrals *completed* (that is, client was know to receive care) rose from 820 in 2004 to 1,319 in 2005.

- **Mental health services.** In every referral category except one, the number of referrals made increased. The only category to show a decline in referrals made was **community mental health services**.

	2004	**2005**
Community Mental Health – Referrals Made	992	946
Community Mental Health – Care Received	466	383
% of referrals completed	45%	40%

This is likely a reflection of the fact that relatively few HCH clients are likely to eligible for publicly funded mental health services, and does not reflect a lack of need for mental health services. HCH providers make referrals to the RSN mental health agencies for all potentially eligible clients.

HCH mental health counselors have some but very limited capacity to provide counseling for clients who are not eligible for mental services at a community-based mental health agency.

Most Common Referrals Made (top 10)

Primary Care Provider/Services	2,875
Social Services Agency[2]	2,583
Community Substance Use Treatment Services	2,229
Housing	1,441
Community Mental Health/Counseling Services	946
Specialty Medical Care	760
Dental Provider	698
DSHS	650
Hospital/Emergency Room/Urgent Care	508
Vision Services	317

Referral Completion

The following tables show the referral types and what we know about whether clients followed through and received care. Interpretation of this data is difficult: it may, for example, be possible that for certain types of referrals (such as referrals to medical care), the HCHN provider is more likely to know the outcome than for other types of referrals (such as referrals to housing or employment). Also, some types of referrals can be acted upon quickly, while others take months or years (waiting lists) for care to actually be received. Taken as a whole, however, the information echoes anecdotal reports from HCHN providers – that medical care and substance abuse services can often be arranged for motivated clients, while mental health services, housing, and dental care are generally more difficult for people to access.

Referrals Made Where Over Half Were Known to Have Received Care

	Referrals Made	Received Care	% of Completed Referrals
Social Services Agency	2,583	1,778	69%
Specialty Medical Care	760	500	66%
Public Health - TB Control Program	37	24	65%
Hospital/Emergency Room/Urgent Care	508	309	61%
Substance Use Treatment Services	2,229	1,319	59%

[2] This line combines several referral categories including financial assistance, entitlements, clothing, food, legal assistance, parenting resources, household items, hygiene services, and others.

Referrals Made Where Fewer than Half Were Known to Have Received Care

	Referrals Made	Received Care	% of Completed Referrals
Primary Care Provider	2,875	1,213	42%
Community Mental Health/Counseling Services	946	383	40%
DSHS	650	240	37%
Nutrition Services (includes WIC)	47	17	36%
Employment/Vocational Services	114	37	32%
Education Services	62	18	29%
Housing	1,441	391	27%
Dental Provider	698	99	14%
Birth to 3/Special Education	29	2	7%
Cognitive Skills Evaluation	8	0	0%

F. Program Updates 2005

1. Third Avenue Center – at YWCA Opportunity Place

Established by a "new access point" federal expansion grant received by Health Care for the Homeless Network, *Third Avenue Center* opened on April 8, 2005. The program is operated by Pioneer Square Clinic – Harborview Medical Center. The two exam room clinic is located at the YWCA Opportunity Place. The program's purpose is to engage homeless people in health, mental health and substance abuse services, and work with them to access ongoing primary care.

- Served **765 unduplicated clients** with 2,197 visits from April – December 2005.
- 63% of patients were women, reflecting the intent to establish a clinic friendly to homeless women.
- Half of all patients were people of color.
- 49% had no health care coverage.
- Top primary health problems:
  1. Upper respiratory infections (17%)
  2. General health screenings (16%)
  3. Musculoskeletal disorders (14%)
  4. Abscess, cellulites, ulcers, infections (11%)

2. Enhanced Tuberculosis Services

The City of Seattle supports TB prevention work with homeless agencies in Seattle. In 2005, Marcia Stone, RN was hired to serve as the liaison for work with homeless agencies.

- There were 23 cases of active TB in homeless people in 2005. All of these cases occurred in the City of Seattle. The 23 cases represented 18% of all TB cases in King County in 2005. For comparison, there were 23 cases of TB in homeless people in 2004, and 35 cases in 2003.

- Held three meetings of the TB Coalition to discuss and clarify TB Prevention and Control Guidelines for homeless serving agencies in King County.

- Provided on-site technical assessments of TB risk at numerous agencies. Agencies made such changes as: adopting written TB policies based on risk for TB (including instituting annual TB skin tests for staff), improving maintenance and functioning of ventilation systems, creating health information bulletin boards for clients, adopting TB orientation/training method for new staff, improving records of client stays and guest visits, and ordering masks to have on hand.

3. *Spotlight on Health Care Access*

The **Health Care Access** program was started at the YWCA in 1995 with the goal of providing education, coverage, and assistance with access issues to homeless families. At that time there was a new Medicaid managed care program called "Healthy Options" and families had to choose medical providers from among ten HMOs. In the years since, the number of plans has dropped to two, so generally the choices are far less complex. But getting and keeping health care coverage can still be complicated for a parent dealing with the crises of poverty and homelessness, domestic violence, and whatever mental illness/emotional trauma, substance abuse issues, or other issues are impacting a family. And we know these issues hit single adults as well.

Maria (not her real name) was a homeless single woman with five children. Her monthly income was only a few hundred dollars. Two of those children had a medical coupon. According to Maria, someone had filled out an application for the other children. She was told that this application would be sent to Olympia, but she grew nervous, waiting with a sick child.

The advocate knew that the application should have been sent to the Community Service Office, so when the records could not be found she initiated a new application for the three children, along with a letter explaining the child's medical issues, whose heart related symptoms included her losing consciousness. The child was referred to Children's Hospital, but the cost of the tests meant that mom had to wait for medical coupons. The advocate intervened to speed things up; the child was seen and doctors began treatment.

Health Care Access' goal is to open access to health care for persons without housing or at risk of homelessness, through informed use of public insurance programs, and assistance with access to other free or low-cost services. **In 2005, the program served over 1,200 adults and nearly 900 children, seeing clients in 20 shelter and transitional housing sites**.

Access Advocates assess eligibility for coverage based on individual and household circumstances. Eligibility for public insurance programs varies, but no-cost coverage is available for all children from families with incomes at or below 250% of the federal poverty level. In addition pregnant women, persons with TANF eligibility, certain persons with disabling conditions, and some others are eligible for no-cost Medicaid coverage. Others may be eligible for coverage through Washington Basic Health, with sliding scale premiums calculated on the basis of household size and income.

In addition to access to care via public insurance programs that serve mostly families, there are resources available to meet some of the health care needs of others, depending upon their circumstances or urgency. **YWCA Eyecare for the Homeless** is a volunteer program providing free eye exams and glasses for people who are homeless and have no other resources. Determination of eligibility and vouchers are available at a range of shelters in King County.

These programs are funded by the Health Care for the Homeless Network of Public Health - Seattle & King County and YWCA private fundraising efforts. *Contact Access Advocates Gilma Reid 206/436-8622 or Jeanne Gleeson 425/226-1266 ext 1011 for further assistance. Or call Scott Pinegar, Director of Health Access Programs at 206/436-8670.*

4. Pathways Home Case Management for Homeless Families

Pathways Home provides intensive case management to homeless families throughout King County, and targets those where at least one major health issue is present. Contract partners are Valley Cities Counseling & Consultation and Puget Sound Neighborhood Health Centers, who form multidisciplinary staff teams that work with families on resolving health issues and accessing stable housing. Referrals are made through intake services at Valley Cities Counseling & Consultation, and the team can carry a caseload of 45 families at any given time.

In 2005 operating year (February 1, 2005 – January 31, 2006):

- 89 homeless families—comprising 337 individuals—received Pathways Home services.
- Of 50 adults in families who entered the project during that year, 28 of them (56%) had a psychiatric diagnosis.

Selected Outcomes
Pathways Home focuses on moving families into permanent housing, addressing underlying physical and behavioral health issues of both the children and adults, and linking families to mainstream health care and other supports.

- 32% of families served by the Pathways Home therapeutic team moved into permanent affordable housing between program intake and discharge (goal is 20%).
- 95% of families assessed to be eligible for mainstream services and not yet receiving benefits were assisted in completing appropriate applications (goal is 80%).

5. REACH Case Management for Chronic Public Inebriates

REACH provides 7.5 full-time equivalent case managers and one nurse at the Dutch Shisler Sobering Support Center to engage chronic public inebriates in case management and housing. HCHN contracts with Evergreen Treatment Services and Pike Market Medical Clinic for the program, which is funded with local revenues. REACH uses motivational interviewing and goal-directed care plans to engage clients in substance abuse treatment, health care, and housing.

REACH Clients 2005

- Provided case management to 136 individuals. Of these, 31 were new clients first engaged in 2005.
- 75% of REACH 2005 clients were male; 26% were female. 44% were Native Americans.
- Case managers carry a caseload of about 20, and they target the highest utilizers of the Sobering Center. Since 1998, 63% to 78% of the "top 60" sobering utilizers of each year were engaged in REACH case management.

Selected Outcomes

- 71% of REACH clients participated in substance abuse treatment in 2005 (Goal is 30%).
- Of new clients engaged in services in 2005, 35% improved their housing stability (Goal is 40%). Including both new and continuing clients, 73% improved or maintained housing stability.
- Of new clients engaged in services in 2005, 64% improved their income situation (goal is 50%).

6. Medical Respite (Recuperation Beds for Homeless Adults)

Medical Respite provides 22 beds and daily nursing care for homeless single adults who need a place to recuperate from an acute illness. Most clients access a Respite bed upon discharge from Harborview Medical Center or other health care settings, making this program a critical resource in discharge planning. Beds for men are at the Salvation Army William Booth Center, and for women at the YWCA Angeline's program. Respite clients access a full psychosocial assessment, social work, and housing linkage services. Harborview Medical Center's Pioneer Square Clinic operates the program under contract with HCHN. The program is one of 28 Medical Respite programs for homeless people nationally.

In 2005 operating year (February 1, 2005 – January 31, 2006):

- 421 homeless people had a stay in the Medical Respite program
  - 279 (66%) of them met the federal definition of chronically homeless[3]
  - 344 (82%) had a disability
  - 65 (15%) were veterans

Medical Respite clients with special needs:

	All Respite Clients	Chronically Homeless Respite Clients
Mental Illness	62%	72%
Alcohol Abuse	64%	75%
Drug Abuse	70%	83%
HIV/AIDS	2%	3%

[3] HUD defines a chronically homeless person as "an unaccompanied homeless individual with a chronic disabling condition who has either been continuously homeless for a year or more OR has had at least four episodes of homelessness in the past 3 years.

Top Five Primary Admitting Diagnoses (what acute health condition qualified them for a Respite stay):

Primary Admitting Diagnosis	Number of clients	% of all admits
Abscesses, cellulitis, ulcers, or infection	186	44%
Pneumonia	60	14%
Fracture	35	8%
Need for post-surgical care	34	8%
Skin disorders/wounds	25	6%

Selected Outcomes

Medical Respite engages chronically homeless people with some of the most serious combinations of physical and behavioral health problems in our community. Many are actively using drugs/alcohol and not using shelter services, and many leave prior Respite prior to completing their recommended stay. Despite this, many clients make significant strides toward stability as a result of a Respite stay.

- 40% (167 out of 421) of clients completed their recommended respite stay and resolved their presenting medical problems. (Goal is 40%)

- 58 (35%) of the 167 Medical Respite clients who completed their recommended Respite stay were discharged to a more stable housing placement than the one they were in prior to entering the respite program. (Goal is 35%)

In an effort to improve the number of Respite patients who transition to stable housing after discharge, HCHN and Pioneer Square Clinic have been actively developing new partnerships with housing programs to take Medical Respite discharges, including the Compass Center and Plymouth Housing Group.

Appendix A – Demographics

2005 Health Care for the Homeless Demographic Summary

	Contracted	Public Health	Total
Total Encounters	42,677	50,065	92,742
Unduplicated Clients	8,148	14,382	22,530

	HCHN Contracted		Public Health Sites		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
AGE						
0-5	427	5%	3,233	22%	3,660	16%
6 through 10	251	3%	258	2%	509	2%
11 through 13	104	1%	130	1%	234	1%
14 through 17	387	5%	763	5%	1,150	5%
18 through 24	1,051	13%	3,646	25%	4,697	21%
25 through 34	1,146	14%	2,883	20%	4,029	18%
35 through 59	4,234	52%	3,053	21%	7,287	32%
60 through 74	501	6%	313	2%	814	4%
75 through 84	44	1%	80	1%	124	1%
85+	3	0%	23	0%	26	0%
Total	**8,148**	**100%**	**14,382**	**100%**	**22,530**	**100%**
RACE/ETHNICITY						
Asian/Pacific Islander	304	4%	1,328	9%	1,632	7%
Black/African American	2,130	26%	2,913	20%	5,043	22%
American Indian/Alaska Native	757	9%	475	3%	1,232	5%
Hispanic or Latino	872	11%	3,050	21%	3,922	17%
Multi-racial	352	4%	649	5%	1,001	4%
People of color total	*4,415*	*54%*	*8,415*	*59%*	*12,830*	*57%*
Caucasian	3,646	45%	5,120	36%	8,766	39%
Race unknown or not reported	87	1%	847	6%	934	4%
Total - all race	**8,148**	**100%**	**14,382**	**100%**	**22,530**	**100%**
GENDER *						
Male	4,530	56%	5,249	36%	9,779	43%
Female	3,618	44%	9,133	64%	12,751	57%
Total	**8,148**	**100%**	**14,382**	**100%**	**22,530**	**100%**
HOUSEHOLD TYPE/SOCIAL UNIT						
Family	1,871	23%			1,871	23%
Individual	5,134	63%			5,134	63%
Unattached Youth	817	10%			817	10%
Unknown	326	4%			326	4%
Total	**8,148**	**100%**			**8,148**	**100%**
HOUSING STATUS						
Street	650	8%	821	6%	1,471	7%
Shelter	2,842	35%	3,230	22%	6,072	27%
Transitional	706	9%	1,318	9%	2,024	9%
Doubled Up	409	5%	6,279	44%	6,688	30%
Other	1,018	12%	2,734	19%	3,752	17%
Unknown	2,523	31%	0	0%	2,523	11%
Total	**8,148**	**100%**	**14,382**	**100%**	**22,530**	**100%**
INSURANCE						
Medicaid	2,874	35%	7,023	49%	9,897	44%
No insurance or unknown	3,918	48%	7,071	49%	10,989	49%
Other Public Insurance	583	7%	8	0%	591	3%
Medicare	590	7%	5	0%	595	3%
Private Insurance	183	2%	275	2%	458	2%
Total	**8,148**	**100%**	**14,382**	**100%**	**22,530**	**100%**

* Gender: HCHN contracted data includes transgendered -- 9 male to female and 1 female to male

Single Adult Females -- 2005 Users With Given Problem
(a user might have more than one problem)

1,742 Users

BY MEDICAL PROVIDERS Health Problem Group	Users	User Rank	Encounters	Encounter Rank	Visits per user	Rank Visits/ Users
Cardiovascular	186	7	633	4	3.4	3
Dental	3		3		1.0	17
Disability	13		13		1.0	17
Endocrine	103	10	446	7	4.3	1
Gastrointestinal	83		204	10	2.5	7
Genitourinary	113	9	153		1.4	14
Health Maintenance	21		34		1.6	12
Immune	4		15		3.8	2
Kidney	9		31		3.4	4
Musculoskeletal	286	3	530	6	1.9	11
Neurological	32		77		2.4	9
No Problem/Screening	205	5	255	8	1.2	16
Nutrition	51		72		1.4	14
Respiratory	319	2	799	2	2.5	7
Skin	407	1	879	1	2.2	10
Social Issue	158	8	232	9	1.5	13
Substance Related	187	6	617	5	3.3	5
Trauma	1		1		1.0	17
Mental Health	236	4	699	3	3.0	6
Anxiety	53		117		2.2	
Depression	170		469		2.8	
Psychoses	14		26		1.9	
Mental Health-Other	42		87		2.1	
Sign/Symptom	659		1,281		1.9	
Other	264		593		2.2	

BY ALL PROVIDERS Health Problem Group	Users	User Rank	Encounters	Encounter Rank	Visits per user	Rank Visits/ Users
Cardiovascular	192	8	657	6	3.4	6
Dental	42		73		1.7	15
Disability	32		57		1.8	14
Endocrine	111	10	461	8	4.2	3
Gastrointestinal	86		210	10	2.4	11
Genitourinary	115	9	160		1.4	18
Health Maintenance	23		36		1.6	16
Immune	4		16		4.0	4
Kidney	9		31		3.4	6
Musculoskeletal	289	6	535	7	1.9	13
Neurological	37		92		2.5	8
No Problem/Screening	220	7	275	9	1.3	19
Nutrition	54		79		1.5	17
Respiratory	324	5	809	5	2.5	8
Skin	408	3	888	4	2.2	12
Social Issue	618	1	2,134	2	3.5	5
Substance Related	386	4	1,970	3	5.1	2
Trauma	11		27		2.5	8
Mental Health	538	2	3,274	1	6.1	1
Anxiety	182		703		3.9	
Depression	370		1,553		4.2	
Psychoses	105		432		4.1	
Mental Health-Other	166		586		3.5	
Sign/Symptom	859		2,070		2.4	
Other	410		1,106		2.7	

Single Adult Males -- 2005 Users With Given Problem
(a user might have more than one problem)

3,392 Users

BY MEDICAL PROVIDERS Health Problem Group	Users	User Rank	Encounters	Encounter Rank	Visits per user	Rank Visits/ Users
Cardiovascular	582	4	2,611	3	4.5	6
Dental	2		2		1.0	17
Disability	12		19		1.6	14
Endocrine	362	8	2,075	5	5.7	4
Gastrointestinal	246	9	977	8	4.0	7
Genitourinary	124		365		2.9	11
Immune	13		82		6.3	2
Kidney	29		89		3.1	9
Musculoskeletal	634	2	1,882	6	3.0	10
Neurological	99		265		2.7	13
No Problem/Screening	499	6	630	9	1.3	15
Nutrition	86		437	10	5.1	5
Respiratory	628	3	1,780	7	2.8	12
Skin	949	1	3,768	2	4.0	8
Social Issue	203	10	254		1.3	15
Substance Related	566	5	4,032	1	7.1	1
Mental Health	395	7	2,289	4	5.8	3
Anxiety	45		202		4.5	
Depression	300		1,679		5.6	
Psychoses	39		216		5.5	
Mental Health-Other	49		192		3.9	
Sign/Symptom	1,297		3,251		2.5	
Other	598		2,188		3.7	

BY ALL PROVIDERS Health Problem Group	Users	User Rank	Encounters	Encounter Rank	Visits per user	Rank Visits/ Users
Cardiovascular	582	6	2,614	5	4.5	6
Dental	2		2		1.0	18
Disability	23		38		1.7	16
Endocrine	362	9	2,094	6	5.8	4
Gastrointestinal	249	10	983	9	3.9	9
Genitourinary	125		367		2.9	12
Health Maintenance	3		3		1.0	18
Immune	13		82		6.3	3
Kidney	30		90		3.0	10
Musculoskeletal	635	4	1,893	7	3.0	10
Neurological	106		297		2.8	13
No Problem/Screening	520	8	699	10	1.3	17
Nutrition	86		438		5.1	5
Respiratory	631	5	1,785	8	2.8	13
Skin	951	1	3,773	3	4.0	8
Social Issue	692	3	3,107	4	4.5	6
Substance Related	809	2	7,682	1	9.5	1
Trauma	8		15		1.9	15
Mental Health	557	7	4,157	2	7.5	2
Anxiety	89		477		5.4	
Depression	384		2,353		6.1	
Psychoses	68		375		5.5	
Mental Health-Other	240		952		4.0	
Sign/Symptom	1,374		3,832		2.8	
Other	867		4,182		4.8	

Children in Families -- 2005 Users With Given Problem
(a user might have more than one problem)

825 Users

BY MEDICAL PROVIDERS Health Problem Group	Users	User Rank	Encounters	Encounter Rank	Visits per user	Rank Visits/ Users
Cardiovascular	2		2		1.0	14
Dental	1		2		2.0	6
Disability	5		5		1.0	14
Endocrine	2		3		1.5	9
Gastrointestinal	5		12	10	2.4	3
Genitourinary	12	9	12	10	1.0	14
Health Maintenance	297	2	466	2	1.6	8
Kidney	2		3		1.5	9
Musculoskeletal	28	8	42	8	1.5	9
Neurological	8	10	22	9	2.8	1
No Problem/Screening	144	4	167	6	1.2	13
Nutrition	40	7	56	7	1.4	12
Respiratory	174	3	370	3	2.1	4
Skin	86	5	168	5	2.0	6
Social Issue	403	1	851	1	2.1	4
Mental Health	66	6	179	4	2.7	2
Anxiety	7		9		1.3	
Depression	27		52		1.9	
Mental Health-Other	48		118		2.5	
Sign/Symptom	445		918			
Other	124		177		1.4	

BY ALL PROVIDERS Health Problem Group	Users	User Rank	Encounters	Encounter Rank	Visits per user	Rank Visits/ Users
Cardiovascular	2		2		1.0	16
Dental	1		2		2.0	6
Disability	6		12		2.0	6
Endocrine	3		6		2.0	6
Gastrointestinal	6		13		2.2	4
Genitourinary	13	9	13		1.0	16
Health Maintenance	299	2	468	2	1.6	12
Kidney	2		3		1.5	13
Musculoskeletal	28	8	42	8	1.5	13
Neurological	9	10	23	9	2.6	2
No Problem/Screening	206	3	398	3	1.9	9
Nutrition	40	7	56	7	1.4	15
Respiratory	175	4	373	5	2.1	5
Skin	89	6	172	6	1.9	9
Social Issue	477	1	1231	1	2.6	4
Substance Related	8		15	10	1.9	9
Mental Health	99	5	374	4	3.8	1
Anxiety	28		87		3.1	
Depression	38		111		2.9	
Psychoses	2		2		1.0	
Mental Health-Other	64		174		2.7	
Sign/Symptom	489		1169		2.4	
Other	135		195		1.4	

Adults in Families -- 2005 Users With Given Problem
(a user might have more than one problem)

1,046 Users

BY MEDICAL PROVIDERS Health Problem Group	Users	User Rank	Encounters	Encounter Rank	Visits per user	Rank Visits/ Users
Cardiovascular	72	7	193	5	2.7	6
Dental	2		2		1.0	18
Disability	13		28		2.2	8
Endocrine	60	8	198	4	3.3	4
Gastrointestinal	14		18		1.3	15
Genitourinary	40		53		1.3	15
Health Maintenance	45		89	9	2.0	9
Immune	1		5		5.0	1
Kidney	8		13		1.6	12
Musculoskeletal	134	3	339	3	2.5	7
Neurological	12		59		4.9	2
No Problem/Screening	100	4	122	8	1.2	17
Nutrition	47	10	71		1.5	14
Respiratory	78	6	128	7	1.6	12
Skin	53	9	89	10	1.7	11
Social Issue	417	1	1,394	1	3.3	4
Substance Related	81	5	154	6	1.9	10
Mental Health	191	2	689	2	3.6	3
Anxiety	54		126		2.3	
Depression	145		483		3.3	
Mental Health-Other	48		80		1.7	
Sign/Symptom	390		1,167		3.0	
Other	167		372		2.2	

BY ALL PROVIDERS Health Problem Group	Users	User Rank	Encounters	Encounter Rank	Visits per user	Rank Visits/ Users
Cardiovascular	74	8	199	6	2.7	8
Dental	80	6	183	8	2.3	10
Disability	14		29		2.1	11
Endocrine	60	9	199	6	3.3	6
Gastrointestinal	17		21		1.2	19
Genitourinary	41		55		1.3	18
Health Maintenance	45		90		2.0	12
Immune	1		5		5.0	2
Kidney	9		14		1.6	16
Musculoskeletal	138	5	351	5	2.5	9
Neurological	14		63		4.5	4
No Problem/Screening	241	3	424	4	1.8	13
Nutrition	48		73		1.5	17
Respiratory	79	7	132	9	1.7	15
Skin	53	10	93	10	1.8	13
Social Issue	845	1	4,369	1	5.2	1
Substance Related	198	4	574	3	2.9	7
Trauma	2		8		4.0	5
Mental Health	340	2	1,697	2	5.0	2
Anxiety	143		448		3.1	
Depression	249		1,011		4.1	
Psychoses	8		31		3.9	
Mental Health-Other	106		207		2.0	
Sign/Symptom	540		2,076		3.8	
Other	298		758		2.5	

Unattached Youth -- 2005 Users With Given Problem
(a user might have more than one problem)

817 Users

BY MEDICAL PROVIDERS Health Problem Group	Users	User Rank	Encounters	Encounter Rank	Visits per user	Rank Visits/ Users
Cardiovascular	3		3		1.0	15
Dental	4		6		1.5	6
Disability	3		4		1.3	12
Endocrine	7		12		1.7	3
Gastrointestinal	29	10	48	10	1.7	3
Genitourinary	122	8	179	7	1.5	6
Health Maintenance	211	2	300	4	1.4	10
Immune	2		2		1.0	15
Kidney	1		1		1.0	15
Musculoskeletal	175	5	348	2	2.0	2
Neurological	7		7		1.0	15
No Problem/Screening	255	1	366	1	1.4	10
Nutrition	21		27		1.3	12
Respiratory	184	4	294	5	1.6	5
Skin	186	3	281	6	1.5	6
Social Issue	128	7	153	8	1.2	14
Substance Related	90	9	131	9	1.5	6
Mental Health	141	6	319	3	2.3	1
Anxiety	49		136		2.8	
Depression	86		137		1.6	
Psychoses	5		5		1.0	
Mental Health-Other	32		41		1.3	
Sign/Symptom	366		588		1.6	
Other	176		252		1.4	

BY ALL PROVIDERS Health Problem Group	Users	User Rank	Encounters	Encounter Rank	Visits per user	Rank Visits/ Users
Cardiovascular	3		3		1.0	17
Dental	4		6		1.5	9
Disability	4		5		1.3	14
Endocrine	7		13		1.9	4
Gastrointestinal	29	10	48	10	1.7	6
Genitourinary	123	8	182	8	1.5	9
Health Maintenance	211	3	302	6	1.4	12
Immune	2		2		1.0	17
Kidney	1		1		1.0	17
Musculoskeletal	179	7	361	4	2.0	3
Neurological	8		10		1.3	14
No Problem/Screening	288	2	417	3	1.4	12
Nutrition	22		28		1.3	14
Respiratory	190	5	308	5	1.6	7
Skin	190	6	291	7	1.5	9
Social Issue	302	1	563	2	1.9	4
Substance Related	105	9	170	9	1.6	7
Trauma	1		6		6.0	1
Mental Health	196	4	733	1	3.7	2
Anxiety	75		300		4.0	
Depression	125		302		2.4	
Psychoses	12		25		2.1	
Mental Health-Other	59		106		1.8	
Sign/Symptom	419		955		2.3	
Other	235		390		1.7	

Appendix C

Health Care for the Homeless Network Advisory Planning Council

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Sheila Sebron, Consumer Representative

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